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Global Initiative on Contraceptive Requirements and Logistics Management Needs in Developing Countries in the 1990s

Report of the Executive Director

Summary

This report has been prepared in response to Governing Council decision 91/35 A, which authorized the Executive Director to continue working with a consultative group of interested parties in order to exchange and update information on contraceptive requirements and related issues, and decision 92/32 A, which requested the Executive Director to submit to the Council at its forty-first session a report on the Global Initiative on Contraceptive Requirements and Logistics Management Needs in Developing Countries in the 1990s. The report is divided into two sections: an update of global contraceptive requirements and a review of the activities of the Global Initiative.

The Executive Director requests that the Executive Board endorse the continuation of the work of the Global Initiative (as requested by the Governing Council in decision 93/27A, para. 10) and authorize UNFPA to make appropriate arrangements, through the use of project funds, to continue the work of the secretariat of the Global Initiative located within UNFPA for a further two-year period, 1994-1996, and to submit to the Executive Board in 1996 a report on the Global Initiative as well as proposals for continuing its work beyond 1996 if necessary.

I. UPDATE OF GLOBAL CONTRACEPTIVE REQUIREMENTS

1. This section of the report provides an update of the global estimates of contraceptive requirements in developing countries, including estimates of condom requirements for HIV/AIDS prevention.[1] This update builds on the earlier global estimates contained in the UNFPA report Contraceptive requirements and demand for contraceptive commodities in developing countries in the 1990s (document DP/1991/34), submitted to the Governing Council at its thirty-eighth session (1991). The update incorporates the latest data from the United Nations, the Demographic Health Surveys, the in-depth country studies conducted under the Global Initiative, and other sources, and includes estimates of condom requirements for HIV/AIDS prevention prepared by the World Health Organization Global Programme on AIDS (WHO/GPA).

2. Contraceptive use by married women. During the period 1994-2005, the number of women 15-49 years of age in developing countries is expected to increase by approximately 22 million a year, from 1,107 million in 1994 to 1,369 million in the year 2005. The number of married women of reproductive age (MWRA) in developing countries is expected to increase by around 14 million a year, a total increase of 169 million, or 21.5 per cent, in the period 1994-2005. In 1994, it is estimated that 446 million married women are contraceptive users in developing countries, constituting 56.8 per cent of MWRA. For the level of contraceptive use to remain the same over the period 1994-2005, there would need to be about 96 million more contraceptive users in 2005 than in 1994, making a total of 562 million, solely because of the large increase in the number of MWRA.

3. In order for population growth to remain in line with the United Nations medium projection, which forecasts an addition of 950 million persons by the year 2005, a modest increase in contraceptive prevalence in developing countries from 56.8 per cent in 1994 to 63 per cent in 2005 would have to take place. This increase of about one-half of one per cent per year in contraceptive prevalence, combined with the large increase in the number of MWRA, yields an increase of 157 million contraceptive users, bringing to 603 million the total number of married women using contraception by the year 2005.

4. In order to reach the United Nations low population projection, the number of contraceptive users would have to reach 622 million in the year 2005, 176 million more than in 1994. The very ambitious goal of attaining replacement fertility for each country in the world would require 269 million additional users in 2005, 60 per cent more than the number in 1994.

5. Of the 446 million users of contraception in 1994, 399 million (90 per cent) use modern methods of contraception; the remaining 10 per cent use traditional methods. Among the modern methods, 85 per cent are female methods and 15 per cent are male methods. Clinical methods (e.g., sterilization, vasectomy, injectables, IUDs, implants) are used by about 80 per cent of all users of modern methods and supply methods (pills and condoms) by 20 per cent.

6. Method use. It is estimated that of the 446 million current users in developing countries, 200 million (45 per cent of all users) are protected by sterilization (80.5 per cent through female procedures and 19.5 per cent by vasectomy). The IUD is the second most used contraceptive method, by 112 million (25 per cent of all users). The pill is used by more than 51 million women (12 per cent of all users), the condom by almost 25 million couples (6 per cent of all users), and although injectable use is probably increasing relatively rapidly in developing countries, survey data indicate that it is used by little more than 10 million women (2.2 per cent). (The remaining 47 million contraceptive users use traditional methods.)

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[1] The update uses a demographic methodology, since at present sufficient data are not available to prepare global estimates based on unmet need. However, the basic purpose of the exercise is to estimate the volume and costs of the contraceptives required to meet the current and future needs of individual women and men.

7. Method mix differs markedly by region. For example, in Asia, sterilization and IUDs account for 76 per cent of users; in Latin America, 38 per cent use sterilization and 28 per cent use the pill. In both sub-Saharan Africa and the Arab States and Europe, the pill is the most used method (26 per cent and 31 per cent, respectively), while sterilization is much less popular. The largest proportionate use of injectables is in sub-Saharan Africa with 13 per cent of all users.

8. Contraceptive use among all women. At the time of the survey, data on contraceptive use among women who were not married were available for 34 countries only -- 13 in Latin America, 20 in sub-Saharan Africa, and 1 in Asia. In the 13 countries in Latin America, the estimated number of contraceptive users among women who were not married was 4.6 million (equivalent to 10 per cent of married women users). In sub-Saharan Africa, there were about 17 million users among those not married (roughly half as many as among married women). The proportion of contraceptive users among the not-married women 15-49 years of age was 17 per cent in sub-Saharan Africa and 9.5 per cent in Latin America. All further estimates in this report are based on total users, both married and unmarried.

9. Contraceptive commodity requirements. In order to achieve the level of contraceptive use projected for 2005, very large numbers of contraceptive commodities will be required. Estimates of contraceptive commodity requirements for the period 1994-2005 are: 196 million sterilization procedures, 436 million IUDs, 898 million doses of injectables, 12.3 billion cycles of pills and 55.7 billion condoms.

10. Cost of contraceptive commodities. The estimated annual cost of such contraceptive commodities for family planning would increase from $528 million in 1994 to $752 million in the year 2005. The total for the 12-year period 1994-2005 is estimated to be $7.7 billion and averages just over $640 million per year. This compares to $5.1 billion for the 10-year period 1991-2000 presented in the original estimate of global contraceptive requirements in 1991, averaging $510 million per year. An additional 14.6 million condoms for the prevention of AIDS and other sexually transmitted diseases (STDs) are estimated to be required for the period 1993-2005 at a cost of $406.5 million. Thus, the total cost of commodities, including condoms for HIV/AIDS prevention, during this period is estimated as $8.1 billion. The breakdown by method is as follows: pills, $2.5 billion; sterilization procedures, $2.0 billion; condoms, $1.95 billion ($1.55 billion for family planning and $0.4 billion for STD/AIDS prevention); injectables, $907 million; and IUDs, $733 million.[2]

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[2] There can be substantial variation in the cost of commodities dependent upon such factors as place of purchase, volume of each purchase, and packaging and shipping. The figures given below are estimated averages for purchases on the international market and include an allowance of 15 per cent added to the "Free on Board" (FOB) price of the good to cover delivery to the port of entry.

Condoms	$0.0278 per piece	
Pills	$0.20 per cycle	
Injectables		
	Depo Provera	$0.92 + $0.05 for needles, syringe, and swabs, per dose
	Noristerat	$1.00 + $0.05 for needles, syringe, and swabs, per dose
IUDs-Tcu 380A	$0.74 + $0.94 for equipment and supplies used for insertions	
Sterilization	$10.375 per procedure	
Norplant	$26.45 for a set of implants + $5.23 for equipment and supplies	

These are current costs, and no cost escalation over the period is included in the projections. The costs of condoms, pills, injectables, and IUDs are about the same in 1993 as they were in 1990. The price of the Norplant implant has increased about 15 per cent since 1990, and equipment and supplies required for sterilization have increased in price by about 5 per cent from 1990 to 1993.

11. The bulk of the costs -- 71 per cent, or almost $5.5 billion -- occur in the Asia and the Pacific region. The Arab States and Europe region account for the smallest proportion of the costs for 1994-2005, at 5.8 per cent ($443 million), though over the 12-year period the annual cost increases by 72 per cent (from $27.4 million in 1994 to $47.3 million in 2005). Sub-Saharan Africa accounts for 8.8 per cent of the total costs ($680 million), but costs in 2005 ($79.8 million) are estimated to be more than double those in 1994 ($35.6 million). Costs of over $1 billion for contraceptives are projected for Latin American and the Caribbean region (14 per cent of the total), with annual costs increasing by just over a third between 1994 and 2005 (from $76.5 million to $103 million).

12. Sources of supply. Governments supply about 86 per cent of all modern methods that are used in developing countries. About 95 per cent of clinical methods (sterilization and IUDs) are supplied by governments; equivalent figures for pills and condoms are 57 per cent and 47 per cent, respectively. These summary figures generally reflect the situation in Asia where the large majority of the population and contraceptive users live.

13. In Asia, governments furnish the supplies for more than 90 per cent of users of sterilization and IUDs, almost 80 per cent of users of pills, more than two-thirds of users of injectables, and about half the users of condoms. Sixty-five per cent of contraceptive users in sub-Saharan Africa receive supplies from governments, primarily injectables, pills and IUDs, and the private sector accounts for 47 per cent of sterilizations and 64 per cent of condoms. In Latin America, 62 per cent of users of modern methods (including more than 80 per cent of users of the pill, injectables, and condoms) receive their supplies from the private sector. Similarly, in the Arab States and Europe, 58 per cent receive their supplies from the private sector (including more than three-fourths of all condom users and two-thirds of all pill users).

14. In summary, governments supply very large proportions of all contraceptives in Asia, particularly clinical methods. In sub-Saharan Africa, the public sector probably is increasingly the source of supply for modern methods of contraception, although almost two-thirds of users of condoms receive supplies from the private sector. In the Arab States and Europe, the private sector supplies more contraceptives than governments do, with the exception of sterilization, and the IUD and injectables are about equally divided between government and private sources. In Latin America, governments supply more sterilizations and IUDs than the private sector does in the ratio of 60/40, but all other methods are largely supplied by the private sector.

15. In 1994, the cost of contraceptive commodities in developing countries is estimated to be $528 million. Taking into account that governments in different countries supply varying proportions of each modern method, it is estimated that the contraceptive commodities provided by governments (including those channeled through multilateral and bilateral donors) will total $398 million in 1994. Donors will contribute approximately $100 million of this figure (based on 1992 data, when the United States Agency for International Development (USAID) spent $39.9 million on contraceptive commodities, and UNFPA, using its own resources, spent $17.1 million, and another $33.9 million on behalf of others, yielding a total of $90.9 million). This suggests that developing country governments will provide approximately 75 per cent of the total costs of contraceptive commodities in 1994. (Almost half of these costs occur in China and India.)

16. According to these figures, the private sector accounts for about 25 per cent of the total, or $130 million. The International Planned Parenthood Federation (IPPF) provided almost $10 million to non-governmental organizations (NGOs) for contraceptive commodities in 1992. A large part of the remaining $120 million were in sales. Pharmacy figures, according to these estimates, account for 4.1 per cent of the total, or $22 million. However, the consumer pays considerably more since the quoted figures are based on large volume, wholesale prices.

17. Projections of condom requirements for STD/AIDS prevention. The assumptions and estimates in this section of the report were prepared by WHO/GPA. The foundation for the projections is an estimate of

the number of condoms being distributed for STD/AIDS prevention in each country in 1993. The 1993 baseline then provides the basis for two estimates (low and high variants) of condom requirements through 2005. For the purposes of this report, the average of the low and high projections is presented. The projection attempts to be as realistic as possible and recognizes that only a portion of the people at risk who should use condoms actually do so. On the other hand, "ideal" demand -- demand by all those who should use condoms -- is not calculated. No one scenario for projecting condom requirements can adequately address the unique conditions that exist in every country and, in particular, the status of the AIDS epidemic and the individual and national response to it in that country.

18. The projection of condom requirements is based on two variables: percentage of men always using condoms and number of condoms per male per year. In the absence of country-specific data on sexual behaviour and condom use in the context of STD/AIDS prevention for most countries, estimates had to be made of these variables. The total male population aged 15-59, urban and rural, is assumed to be at risk of STD/HIV infection because they are all, to some extent, likely to be sexually active.

19. Men always using condoms represents the number of men assumed to use condoms for "every" high-risk sexual encounter during the year. This variable is assumed to increase in response to promotional condom campaigns. For the low variant, it is assumed that the number of men using condoms increases by 5 per cent in 1994-1995 and by 3 per cent during 1996-2005. The annual increases in the high variant are 15 and 5 per cent for the two periods respectively. The number of condoms per male represents the number of condoms per male per year that could be used during high-risk encounters (estimated at 20 condoms for the low variant and 38 condoms for the high variant, per male per year).

20. The requirements of condoms for STD/AIDS prevention in developing countries is estimated to be about 525 million in 1993, 815 million in 1994, and 1,517 million in 2005. The cost of condoms would be approximately $22.6 million in 1994, and would increase by 5 to 6 per cent each year thereafter. In 2005, the estimated costs of condoms for HIV/AIDS prevention would be $42.1 million. The total number of condoms required for 1993-2005 would be 14,635 million, and the cost would be about $406.5 million, an average of $31.3 million per year. The numbers of condoms required, according to these estimates, are large, but the number of condoms per male aged 15-59 per year is relatively small -- only 5 per male per year in sub-Saharan Africa in 1995 and fewer in the other regions.

21. The developing countries in the Arab States and Europe region are estimated to account for only a small proportion of the total, just over one-half of one per cent of the developing country total. Latin America accounts for about 6 per cent, and Asia is estimated to need 31 per cent of the total requirements (29 per cent in 1993, increasing to 32 per cent in 2005). Sub-Saharan Africa is estimated to have the greatest need by far -- 61 per cent of all users in 1995, and 60 per cent during the period 1993-2005, even though males aged 15-59 in sub-Saharan Africa are only about 10 per cent of all males aged 15-59 in developing countries.

II. ACTIVITIES OF THE GLOBAL INITIATIVE ON CONTRACEPTIVE REQUIREMENTS AND LOGISTICS MANAGEMENT NEEDS

22. Following decision 91/35 A, taken by the Governing Council at its thirty-eighth session, and the recommendations of the 31 May 1991 Follow-up Consultative Group Meeting on Contraceptive Requirements, a small working group of interested parties was formed to guide and steer in-depth country studies of contraceptive requirements and logistics management needs. The working group held its first meeting at UNFPA headquarters on 16 September 1991 to initiate action on the implementation of the Global Initiative and, inter alia, to discuss the 12 countries proposed for study at the 31 May 1991 meeting: Bangladesh, Brazil, Egypt, India, Mexico, Nepal, Nigeria, Pakistan, the Philippines, Turkey, Viet Nam and Zimbabwe.

23. UNFPA sought funding for a two-year project, 1992-1993, to establish a small secretariat consisting of two professional staff (logistics management adviser and technical adviser-programme) and one support staff

to plan, manage and implement the in-depth country studies. Support was provided by the Swedish International Development Authority (SIDA), the Rockefeller Foundation, and the World Bank in the total amount of $571,248. Staff recruitment was completed by July 1992.

24. Simultaneously, UNFPA developed and obtained approval for an interregional project for $570,000 to cover 1992-1993 operational costs related to the in-depth studies, the meetings of the working group, and the annual meeting of the Consultative Group. Both of these projects have sufficient funds available to enable the Global Initiative to carry out its work until the end of June 1994.

25. During 1992-1993, in-depth studies were completed in the following countries (in chronological order): Pakistan, Zimbabwe, India, Nepal, Turkey, Viet Nam and the Philippines. In addition to projecting contraceptive requirements over a 10-year period, the in-depth country studies also focus on the areas of logistics management needs, the role of NGOs and the private sector in family planning service delivery, condom requirements for STD/AIDS prevention, options for local production, and trends in the sources and uses of funds for contraceptive commodities and logistics management needs. The missions reflected the collaborative nature of the Global Initiative in that of 40 team members who worked on the seven studies, 15 were supported by the following international donors and agencies: IPPF, the United Kingdom Overseas Development Administration (ODA), the Rockefeller Foundation, SIDA, USAID, the World Bank, and WHO/GPA.

26. Reports of all the in-depth studies have been published and widely disseminated. During 1993, UNFPA also published and disseminated Contraceptive Procurement: Options for Programme Managers. French and Spanish translations of this document were published in 1994.

27. In addition, at the request of the working group, UNFPA, in conjunction with IPPF, USAID and WHO/GPA, has undertaken to develop a database on contraceptive commodity provision in developing countries. A key function of the database will be to facilitate and encourage coordination and cooperation in the area of contraceptive requirements, both among donor agencies and between donor agencies and governments.

28. In 1993, as per the recommendation of the working group and the Consultative Group, UNFPA requested its Country Directors in those countries where studies had been completed and reports published (Pakistan, Zimbabwe, India and Nepal) to work closely with the Government in developing a follow-up action plan providing a specific time-frame and a clear designation of responsibilities among government organizations, donors, UNFPA and, as appropriate, NGOs and the private sector in order to implement the recommendations of the in-depth study.

29. Upon completion of the 12 in-depth studies, UNFPA intends to prepare, publish and widely disseminate a report or reports on lessons learned from the in-depth studies, on how to prepare for and conduct an in-depth study, and on the methodology used in the studies. It is expected that these reports will provide a source of technical expertise and knowledge for those countries wishing to conduct their own studies.

30. Most activities currently foreseen under the Global Initiative will be completed by mid-1995. As regards future directions, the main areas for consideration are: to conduct medium-term follow-up analyses of the in-depth studies; to provide technical assistance and support to training in logistics management and projections of contraceptive requirements; to strengthen the coordinated procurement of contraceptive commodities; to devise cost-sharing and cost-recovery schemes for family planning services; and to examine in greater depth human resource requirements for the provision of family planning services.